

# MEDICAL CONTROL COMMITTEE

February 28, 2003

## Minutes

<u>Members Present:</u>	<u>Others Present:</u>
Dr. Ed DesChamps, Chairman	Alonzo Smith, DHEC EMS
Dr. Carol Burger	Phyllis Beasley, DHEC-EMS
Dr. John Sorrell	Robert Wiinn, Meducare
Dr. Doug Norcross	Dr. Garrett Clanton
	Doug Rorie, First Health
	Ernie Autry, First Health

Dr. DesChamps said that the Committee was missing a number of members, so he changed the order of the agenda in case of any late arrivals.

### MINUTES FROM NOVEMBER 2002

Dr. Norcross made a correction on Page 6: Dr. Karl Byrne is chairman of the SC Chapter of the ACS, not the Committee on Trauma.

**Dr. DesChamps made a motion to approve the minutes with Dr. Norcross' suggested change. The motion was seconded. The motion was approved.**

### TRAUMA SYSTEM REPORT

Dr. Norcross noted that at the last Trauma System Committee meeting, the Level III redesignation report for Self Memorial Hospital was reviewed. The Committee voted to approved the redesignation of Self Memorial under redesignation option #2 (the hospital has 90 days to make corrections noted by the Committee; in this case the hospital must find a surgeon to be trauma director).

He also said that the Level I redesignation requests were sent out. The deadline to respond was February 28. To date, only MUSC and Spartanburg had responded; but Ms. Beasley said that other letters might be in her office, she has been out of town.

Dr. Norcross also reported that the trauma legislation stakeholders group had met and gave final approval to draft trauma legislation. He said that now the DHEC legal staff must review the document and make appropriate changes.

Dr. DesChamps mentioned that the trauma video has been produced and released. Ms. Beasley said that a change is currently being edited in to reflect the more accurate figures

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of the losses of Level I and II trauma centers released recently in the Bishop and Associates study.

Ms. Beasley talked about plans to get copies of the video to all trauma centers for use in presentations to their communities.

### **DRUG REQUESTS**

Dr. DesChamps said the Committee members who are present would review the drugs and then send their recommendations to the absent members for their vote.

#### **Amiodarone (Cordarone) for use in Pediatrics:**

This request for change in use was submitted by Sumter County EMS and Dr. Garrett Clanton.

Dr. Clanton had talked with Dr. Ringwood of the EMS-C Committee and he is in favor of adding amiodarone; additionally, amiodarone for pediatrics is included in ACLS guidelines.

Dr. Clanton said he didn't think this would be used often, but he felt that when it is needed, he wants his paramedics to feel comfortable with its use. Dr. DesChamps said that since it is listed in AHA guidelines, it is appropriate for this committee to approve it.

Dr. Burger asked for clarification on the last approval of amiodarone. She asked if it had been approved for the indications of v-fib and unstable v-tach, or did the Committee say it could be given for atrial rhythms or anything else? Dr. DesChamps said it had been approved for v-fib and v-tach. Dr. Burger asked if it should be opened up for other uses. Dr. DesChamps said that there is another request, from First Health of the Carolinas, for its use for supraventricular tachycardia unresponsive to adenosine.

Dr. DesChamps asked the Committee to first address its use in pediatrics. Dr. Clanton said that his request also includes the use of amiodarone in perfusing arrhythmias with online order.

The Committee discussed the requirement of online order for perfusing arrhythmias versus standing orders. Dr. Clanton pointed out that the request from First Health calls for standing orders.

Dr. Burger said that pulseless and unstable v-tach should be kept in standing order and for pediatrics and for other arrhythmias have online medical control. Dr. DesChamps summarized the discussion by saying that amiodarone should be opened up for pediatric indication for pulseless rhythms by standing order at the appropriate doses and to add perfusing rhythms in both adults and peds only by online or direct medical order. Dr. Clanton suggested that it read by online order for stable arrhythmias.

**Dr. Sorrell made a motion to add the use of amiodarone for clearly unstable and pulseless v-tach and v-fib in pediatrics in the appropriate pediatric dose. The motion was seconded. The motion was approved.**

**Dr. Norcross made a motion to add the use of amiodarone for stable and perfusing rhythms in both adults and pediatrics. He said that indication would require direct medical order. Dr. Burger seconded the motion. The motion passed.**

*Dr. DesChamps suggested that prior to the publication of the drug changes that a notification of the Medical Control Committee's actions should be sent to the EMS-C Committee and a response back from them should be taken to the Advisory Council.*

Robert Winn of Meducare asked about instances when there is a long transport time and a patient arrests and the paramedics use amiodarone to respond, but there is still a long, e.g. two hour remaining trip, what about maintenance drips? Or do they have to go to the closest hospital because there is no more amiodarone on the truck because it is so expensive? Dr. Sorrell said that continuous infusion of amiodarone is already allowed. He said it would be up to the local medical control to carry enough.

### **Levalbuterol HCl / Xopenex**

Requested as an addition to the drug list by Greenville County EMS

Dr. Burger requested that Xopenex be approved as an alternative to albuterol. Dr. Burger said that Xopenex is more expensive; therefore its use would be up to the individual service. But most studies have shown that the effects of Xopenex last longer, but for the prehospital setting it appears to have a 20% improvement in FEV1 over the albuterol. She said they are getting to the point where they pick up people who have already had two or three albuterol treatments at home and they are no better; approval of this drug would add to their armamentarium and might prevent intubation. She said that Xopenex is FDA-approved to age 6, but even Albuterol is not approved for children under age 6. Dr. Burger said she is not requesting to replace Albuterol, just give medical control physicians another option.

Dr. Sorrell commented that the same drug page would be written for Xopenex as for albuterol; it appears to be the same dosages. Dr. Burger said it should be written the same as albuterol for pediatric patients.

It was mentioned that Atrovent is also up for discussion. Dr. DesChamps commented that he often uses Xopenex and Atrovent in the same nebulizer.

Dr. Burger commented that the suggested dosage for Xopenex is “up to 1.25 mg” – dosages are based on how sick the patient is, not their age.

**Dr. Sorrell made a motion to approve Xopenex in the same format as Albuterol. Dr. DesChamps seconded the motion. The motion was approved.**

**Ipratropium Bromide / Atrovent:**

Submitted as an addition to the drug formulary by FirstHealth EMS

Dr. DesChamps asked if anyone had ever seen any adverse reaction to Atrovent. Dr. Clanton said that people with peanut allergies will have a significant reaction to Atrovent. He said he thought that was only with the metered dosage, not with the solution for nebulizer.

Dr. DesChamps said that under the note section, if it is approved, it should be noted that it is allowable to mix Atrovent and Xopenex.

Dr. Burger asked if there were a restriction on how often you can use Atrovent. Dr. Clanton said it is not an acute phase reactor; it is usually dosed every four hours. Dr. Sorrell said that it appears the guidelines for Atrovent would be the same as albuterol.

Dr. Burger said she was inclined to allow for one dose. Dr. DesChamps suggested allowing one dose per standing order and any additional doses require direct medical order. Dr. Sorrell said that for albuterol, the statement is “repeat treatments per local protocol.”

**Dr. Burger made a motion to add Atrovent as written, for all ages and groups. In note section add “can be mixed with Xopenex and albuterol”, one dose per standing order; any repeat doses with Atrovent require direct medical order. Dr. Sorrell seconded the motion. The motion passed.**

**Dexamethasone / Decadron:**

Submitted as an addition to the drug formulary by FirstHealth EMS

Dr. DesChamps said Decadron was submitted as a drug for wheezing and, at the same time, a request for a pilot project to use Solumedrol for asthma and anaphylaxis has been submitted. He asked the Committee if they want to look at either as a steroid for asthma or both for the prehospital setting. The question was asked if both were needed on the list; or if either was needed.

The question was also posed about steroids taking four to six hours for steroids to take effect and whether there is really any need for this in the prehospital setting.

Alonzo Smith also asked the Committee to consider the necessity of adding this drug; he said that the EMT’s are being asked to be responsible for an enormous number of drugs and the drug formulary is a huge document. He said the Committee really needs to consider carefully adding new drugs and whether they are really essential to functioning in the prehospital setting.

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Dr. Norcross asked if this drug would make a difference in morbidity and mortality. Dr. Burger said that in the situation in which it would be used, there are other drugs in the armamentarium to use first.

**There was no motion to approved Dexamethasone/Decadron.**

**Acetaminophen / Tylenol:**

This drug was submitted as an addition to the drug list by FirstHealth EMS

Tylenol was submitted as a means to control mild to moderate pain or fever.

Dr. DesChamps said that this is currently on the drug list for pediatrics, and it was not added for adults because it was felt that there were other alternative, more effective, treatments for adults. There was discussion that if it were already on the list for pediatrics, it wouldn't be much change to add for adults. The comment was also made that administration of Tylenol could affect an anesthesiologist's treatment at the hospital.

**There was no motion to approve acetaminophen/Tylenol.**

**Ibuprofen / Motrin:**

This drug was submitted as an addition to the drug list by FirstHealth EMS.

Dr. Burger re-stated that the drug list already includes a drug to treat pain and fever in children and another is not needed. Dr. DesChamps said the drug was submitted to treat fever in children.

**There was no motion to approve ibuprofen / Motrin.**

**Magnesium sulfate:**

This drug was submitted as a change in use to the drug list by FirstHealth EMS.

This drug is already on the drug list for the indications cited in the request. The representatives from First Health said they must have an old copy of the drug list that do not include the AHA changes.

**There was no motion to approve magnesium sulfate.**

**Famotidine / Pepcid:**

This drug was submitted as an addition to the drug list by FirstHealth EMS.

Pepcid is being submitted as an indication for ulcers and gastroesophageal reflux disease and allergic reaction.

The comment was made that Pepcid is not FDA-approved for the indication of allergic reaction. Dr. DesChamps said the DHEC would not approve a drug that is not FDA-approved for that purpose. Dr. Burger said that if someone is suffering from severe anaphylaxis, they will be treated with epinephrine, not this.

**There was no motion to approve famotidine / Pepcid.**

**Tuberculin Purified Protein Derivative Diagnostic Antigen/Tubersol:**

This drug was submitted as an addition to the drug list by FirstHealth EMS.

This drug was submitted for use in testing their own personnel for tuberculosis, rather than having to go through the local Health Department.

Dr. DesChamps said the DHEC Board would not approve this; that the Health Departments are set up to provide this testing. He also said that this drug has nothing to do with patient health and care.

Dr. Clanton said their medical control physician could do this for them anyway. The FirstHealth representative said their medical control physician does not practice in their county.

Mr. Smith said this action goes outside the scope of practice of a paramedic.

**There was no motion to approve Tubersol.**

**Propofol / Diprivan:**

This drug was submitted as an addition the drug list by MUSC Meducare.

This drug was submitted to use in interfacility transports and to allow EMT's to titrate this in long transports. The interfacility form does not allow EMT's to titrate, when the patient starts to wake up during a long transport. Mr. Wynn said they have had three incidents during the last four months when during a long (hour and a half) transport, the patient has started to wake up.

Dr. DesChamps suggested that the interfacility form be adapted to allow titration up with direct medical order.

The Committee discussed the need for interfacility transports to be allowed to titrate drugs up.

Dr. DesChamps clarified that an allowable change in titration would have to be written in the order on the interfacility form for that patient.

Dr. Burger said that she has concerns that if paramedics are allowed to titrate the drugs, they will not be familiar with the drugs that they are increasing. She said, however, that paramedics are caught in an awkward situation, especially in cases of long transports. She said that, hopefully, the sending physicians will discuss the drugs being transported with the paramedics. Dr. Sorrell said he suspects that in most cases the physicians are not reviewing the drugs with the paramedics.

There was discussion that EMS providers should understand that if their EMT's do not have a signed interfacility form or direct medical orders to titrate drugs, then they should refuse to transport or the EMS provider could lose their license.

**Dr. Norcross made a motion to change the language of the interfacility form to allow medications begun prior to transport to be titrated up or down for effect only with direct medical order (written or verbal). Dr. Sorrell seconded the motion.**

Mr. Winn asked if a patient is transported from one hospital to another for tests and is then transferred back to the original hospital, does there have to be a separate interfacility form? The Committee said “no”, if there are no new drugs added and the patient is going back to the original hospital, then no new form is needed.

Dr. Burger said that when this information and the new drug form is sent out, it should be reiterated that it is absolutely required that direct medical orders are imperative.

**The motion passed.**

**There was no motion to approve Diprivan; the issue was addressed by the motion to change the interfacility form.**

### **SOLUMEDROL PILOT PROJECT**

Fort Mill Rescue Squad submitted a request for a pilot project using Solumedrol in the prehospital setting to begin early treatment of bronchoconstriction, since transport times for Fort Mill Rescue Squad can be lengthy. Fort Mill's average transport time is 25 minutes. The medical control physician, Dr. Joel Haling, would like to determine if early administration of Solumedrol would keep chronic asthma patients from being admitted.

Dr. DesChamps asked if the squad was going to be able to get information about hospitalizations of patients treated with Solumedrol. The Fort Mill Rescue Squad representative said that Dr. Haling could get that information for the patients transported to Piedmont Medical Center, but it would be difficult to get the information on patients transported to hospitals across the state line.

Dr. Sorrell said the best information to get is how much sooner was the patient able to get Solumedrol if it were administered in the field versus when the patient got the medication if it were administered in the hospital setting.

There was discussion about whether Fort Mill Rescue Squad would be able to get the information to track when the patient received the medication.

Dr. Clanton said that he was not certain what this study would prove. He said that it is already known that the sooner the patient receives Solumedrol, the sooner the effect will be. He said if the study is prehospital steroids in general, then perhaps the Medical Control Committee should go back and address the issue of the use of prehospital steroids in general.

Mr. Smith said that years ago Solumedrol was carried on the trucks but he couldn't remember why it was taken off. Robert Winn said that it was taken off because no one ever used it. Dr. Burger said that Greenville County's trucks don't have much room left for more drugs.

Dr. Sorrell asked if there was a "down" side to doing the project. Dr. Burger replied that it would only be a shame for the service to put a lot of work into it and the information wouldn't be useful or be approved later.

*The discussion to approve the pilot project was tabled until a Medical Control Committee meeting with greater attendance and until further information was available about the use of Solumedrol in the prehospital setting in other parts of the country.*

#### ADDITIONAL DRUG REVISIONS

Dr. DesChamps said that Dr. Ralph Shealy had asked the Medical Control Committee to review revising a few drugs. Dr. DesChamps said that under Cyanide Poisoning both sodium nitrite and sodium thiosulfate call for direct medical order. He said that if someone had cyanide poisoning, the EMS personnel don't need to wait for a physician's approval to administer the antidotes. **Dr. DesChamps asked Dr. Sorrell and the Committee if this requirement should be removed and it was agreed to do that. He said that for organophosphate poisoning, atropine sulfate, sodium nitrite and sodium thiosulfate and also pralidoxime should also be changed to standing order. All are drugs listed on the special purpose drug list. The Committee agreed by consensus to put these drugs on standing order.**

#### BLOOD CHANGE IN INTERHOSPITAL TRANSPORTS

Mr. Winn of Meducare said that twice in the last month, trauma patients that they had been transporting ran out of the blood that was hung and even though they were carrying additional blood that had been cross typed and matched, they couldn't hang it.

Dr. Norcross said that the hospital should have considered whether the patient was stable enough to transport or should have sent a nurse along. Mr. Winn said that often the hospitals don't have enough nurses to send one.

Dr. DesChamps said he would like to hear more input from the absent members of the Committee.

Dr. Norcross said he would like input from the blood bank personnel

Mr. Winn said that he was told that under the nursing act in state law only RN's can initiate blood, but he said that he could not find that law.

*Dr. DesChamps asked staff to contact other states to find out what their policies are. One of the guests (unable to identify voice from tape) volunteered to do a net search on other states' policies.*

### **TRANSPORT WITH CONTINUOUS FEEDING TUBES**

Mr. Winn said he had another issue that he was requesting a response for. He said that in transporting continuous feeding tubes, in the protocol it says that continuous feeding should be discontinued. He said that they transported a 5 year old who was paralyzed to Atlanta, a four to five hour drive (air transport not available). The child had a tube and trach and had to be continuously hydrated. Mr. Winn said he couldn't find why this was restricted.

Dr. Norcross said it was because whenever a patient is moved, there is a chance that the tube position is changed or dislodged and it would be critical if the patient were to receive a feeding that went into the bronchus.

Dr. Sorrell said that he thought that sometime ago the Committee had determined that if a procedure could be done at home by the patient's family, then it could be done by EMS.

Dr. Sorrell said that in the interfacility device list, a distinction is made between NG and oral gastric tubes versus surgically placed GI tubes. Mr. Winn said he was talking about peg tubes. Dr. DesChamps said that continuous feeding tubes should be considered an interfacility drug that can be continued.

**The Committee agreed to change the interfacility list to reflect that NG tube feeding should be discontinued during transports and that surgically implanted tubes can be continuous feed.**

### **TRANSFER OF EMS PATIENTS DIRECTLY TO ED TRIAGE AREA**

This discussion was postponed until Dr. Gerard's attendance, since he has requested discussion of this topic.

Dr. Norcross asked if the drug formulary could be put on Palm Pilot. Dr. Clanton said it could, that there is a Palm program that takes Word files. Dr. Norcross suggested putting that on the EMS website. Dr. Clanton said the program is called “Word to Go.”

Dr. Sorrell asked about the medication storage issue. Ms. Beasley said she had called Florida to ask about their law and had not gotten a response back.

The next meeting is tentatively scheduled for Thursday, May 15.

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**AGENDA ITEMS NOT COVERED (OR TABLED):**

- Solumedrol Pilot Project
- Blood change in interhospital transports
- Transfer of EMS patients directly to an ED triage area

**ITEMS NOT COVERED FROM PRIOR MEETING:**

- Discussion/determination regarding medicine storage policies

**STAFF ACTIONS NEEDED:**

- Check on Florida statutes regarding medication storage
- Notify EMS-C Committee regarding approved changes in Amiodarone for pediatrics
- Research what other states allow about administering blood in interhospital transports

# MEDICAL CONTROL COMMITTEE MOTIONS

## NOVEMBER 2002

- **(Information Only) The Medical Control Committee agreed by consensus that scene time determinations should be a local, individual policy and decisions.**
  
- **(Information Only) The following redesignation decisions were confirmed by the Advisory Council by fax vote:**

**Dr. Norcross made a motion to redesignate Piedmont Medical Center as a Level III trauma center under Redesignation Option #1 ( “To designate the hospital as a trauma center. The hospital has everything required and is designated with no question or problems.”). Dr. Gerard seconded the motion. The motion passed.**

**Dr. Norcross made a motion to designate Marion County Medical Center as a Level III trauma center under Designation Option #1 1 (“To designate the hospital as a trauma center. The hospital has everything required and is designated with no questions or problems.”) Dr. Gerard seconded the motion. The motion was approved.**

- Prehospital Thrombolytics

Dr. DesChamps presented the Retavase checklist developed by Greenville during the pilot project. He said that is an “inclusion/exclusion checklist”, a “thrombolytic therapy” text page, and two flow sheets. He said that when the Committee approved statewide thrombolytics, that Greenville’s protocols and checklists would be adapted and used statewide.

The was discussion about if there is a “yes” answer to any of the above in the checklist, then medical control should be contacted for instructions.

Dr. DesChamps said that the Committee agreed that the Retaplast recombinant checksheet will be amended to say that any “yes” must be reported to medical control and a direct order must be received for thrombolysis. Dr. Gerard said that the title should be changed to “checklist” instead of “inclusion/exclusion”.

**Dr. Fuerst made a motion to accept the checklist as amended. Dr. Sorrell seconded the motion. The motion passed. Dr. Norcross abstained from voting.**

- **Change of Administration of Valium**

**Motion to change the route of administration of Valium to add IM, and add CANA kit auto-injector or 10 mg IM as a one-time dose in suspected terrorist event. Dr. Rogers seconded the motion. The motion passed.**

➤ **Changes to required equipment (esp. re: helicopters)**

Dr. DesChamps asked if staff had determined whether the repair equipment required of ambulances could be taken off the requirement list for helicopters. Mr. Catoe said that Mr. Horton had been checking into that, but they had not made a determination.

There was discussion about how difficult it is to make changes in equipment requirements when they are in regulation, not policy, but that in the past, legislators have wanted to leave the equipment requirements in regulations.

**The Committee agreed by consensus that the EMS Division should try again to convince the legislators to change equipment to policy rather than regulations.**

➤ **Equipment storage (Information Only)**

Dr. Sorrell said that Florida passed a regulation that drugs must be kept in a controlled environment, and that maybe it is time for South Carolina to consider doing that. Dr. Sorrell said that the issue is not whether the drugs should be kept in a controlled environment, but what is the cost and how hard is it to do this?

Dr. Sorrell suggested contacting Florida regarding their guidelines. Dr. Rogers said that Earl Floyd with Marion County EMS reported that it costs about \$300-400 to buy a storage unit. Dr. DesChamps said there would be additional costs in separating controlled and non-controlled drugs.

*Dr. Rogers volunteered to ask Earl Floyd to bring the information to the Symposium. The Committee asked DHEC EMS to contact Florida about their regulations.*

**FEBRUARY 2003**

➤ **Motion to add the use of amiodarone for clearly unstable and pulseless v-tach and v-fib in pediatrics in the appropriate pediatric dose. The motion was seconded. The motion was approved.**

➤ **Motion to add the use of amiodarone for stable and perfusing rhythms in both adults and pediatrics. He said that indication would require direct medical order. Dr. Burger seconded the motion. The motion passed.**

➤ **Motion to approve Xopenex in the same format as Albuterol. Dr. DesChamps seconded the motion. The motion was approved.**

- **Motion to add Atrovent as written, for all ages and groups. In note section add “can be mixed with Xopenex and albuterol”, one dose per standing order; any repeat doses with Atrovent require direct medical order. Dr. Sorrell seconded the motion. The motion passed.**
  
- **Change in Interfacility Form**

There was discussion that EMS providers should understand that if their EMT's do not have a signed interfacility form or direct medical orders to titrate drugs, then they should refuse to transport or the EMS provider could lose their license.

**Dr. Norcross made a motion to change the language of the interfacility form to allow medications begun prior to transport to be titrated up or down for effect only with direct medical order (written or verbal). Dr. Sorrell seconded the motion. The motion passed.**

- **Solumedrol Pilot Project (Information Only)**

Fort Mill Rescue Squad submitted a request for a pilot project using Solumedrol in the prehospital setting to begin early treatment of bronchoconstriction, since transport times for Fort Mill Rescue Squad can be lengthy. Fort Mill's average transport time is 25 minutes. The medical control physician, Dr. Joel Haling, would like to determine if early administration of Solumedrol would keep chronic asthma patients from being admitted.

*The discussion to approve the pilot project was tabled until a Medical Control Committee meeting with greater attendance and until further information was available about the use of Solumedrol in the prehospital setting in other parts of the country.*

- **Changes to Special Purpose Drugs**

Dr. DesChamps said that Dr. Ralph Shealy had asked the Medical Control Committee to review revising a few drugs. Dr. DesChamps said that under Cyanide Poisoning both sodium nitrite and sodium thiosulfate call for direct medical order. He said that if someone had cyanide poisoning, the EMS personnel don't need to wait for a physician's approval to administer the antidotes. **Dr. DesChamps asked Dr. Sorrell and the Committee if this requirement should be removed and it was agreed to do that. He said that for organophosphate poisoning, atropine sulfate, sodium nitrite and sodium thiosulfate and also pralidoxime should also be changed to standing order. All are drugs listed on the special purpose drug list. The Committee agreed by consensus to put these drugs on standing order.**

- **Question re: blood transfusion (information only)**

Mr. Winn of Meducare said that twice in the last month, trauma patients that they had been transporting ran out of the blood that was hung and even though they were carrying additional blood that had been cross typed and matched, they couldn't hang it.

Mr. Winn said that he was told that under the nursing act in state law only RN's can initiate blood, but he said that he could not find that law.

*Dr. DesChamps asked staff to contact other states to find out what their policies are. One of the guests (unable to identify voice from tape) volunteered to do a net search on other states' policies.*

➤ **Change to Interfacility List (Surgically Implanted Tubes)**

Mr. Winn said he had another issue that he was requesting a response for. He said that in transporting continuous feeding tubes, in the protocol it says that continuous feeding should be discontinued. He said that they transported a 5 year old who was paralyzed to Atlanta, a four to five hour drive (air transport not available). The child had a tube and trach and had to be continuously hydrated. Mr. Winn said he couldn't find why this was restricted.

**The Committee agreed to change the interfacility list to reflect that NG tube feeding should be discontinued during transports and that surgically implanted tubes can be continuous feed.**

# MEDICAL CONTROL COMMITTEE

July 10, 2003

## MINUTES

<u>Members Present:</u>	<u>Others Present:</u>
Dr. Ed DesChamps, Chairman	Alonzo Smith.
Dr. Doug Norcross	Jim Catoe
Dr. Raymond Bynoe	Phyllis Beasley
Dr. John Sorrell	Cindy Kinney, RN
Dr. Ron Fuerst	Pam Lee, RN
	Greg Kitchens
	George Condon
	Edward Lee
	Tim Gault
	Todd Whitaker

## MINUTES

There were no suggested changes to the minutes from the February 28, 2003 minutes. **Dr. Norcross made a motion to approve the minutes; Dr. Sorrell seconded the motion. The motion passed.**

## TRAUMA SYSTEM COMMITTEE REPORT

Dr. Norcross explained to the committee that since it met last, DHEC had introduced legislation to formalize and fund the state's trauma legislation. He said that it was introduced in May and would be considered by the legislation in the next session that begins in January 2004.

He also announced that DHEC had plans to purchase a webpage on the Washington State Hospital's bed capacity website that would allow hospitals, disaster management teams and EMS to monitor bed capacity status which would assist with diversion problems

He said that at the Trauma System Committee meeting prior to this meeting, the Committee reviewed Self Regional Healthcare's response to the Committee's redesignation recommendation from its December 2002 requirement that the hospital find a trauma director within 90 days. He said that upon request of the vice president of Self Regional Healthcare, Ms. Beasley granted the hospital an additional 60-days to continue negotiations to find a trauma director; this deadline was May 10. The hospital then sent a letter stating that "Dr. Edward J. Rapp II and Dr. John D. Konsek have agreed to serve as Co-Trauma Directors.....We see this situation to be interim/temporary in that it is

everyone's resolve to move to a permanent appointment within sixty days." He said that there was much debate and discussion about the redesignation and that the *Committee eventually passed motions to say "that the hospital had met the terms of the redesignation requirement if the committee receives confirmation from the hospital of an appointment of a permanent trauma director or co-directors within the 60 days specified in the letter (deadline of August 1) and that evidence of a QA meeting and evidence that the trauma director(s) are actively involved in QA should be included in the letter expected from the hospital by August 1. A second motion was passed that said "By August 1, a letter must be received from the hospital and signed by the permanent director or co-directors stating that they have assumed the position. Additionally, the hospital should send evidence of all QA activities in which the permanent director or co-directors have been involved, and, if the trauma co-director positions have been assigned, then the letter must include the specific job descriptions and how the duties of the role of trauma director have been divided."*

**Dr. Norcross made a motion to approve the Trauma System Committee's recommendation. Dr. Sorrell seconded the motion. A vote was taken. There was one opposed, Dr. Bynoe, and four in favor. The motion passed.**

### **SOLUMEDROL PILOT PROJECT**

Deferred to a later date.

### **COBRA TEAMS**

Todd Whitaker with the Emergency Management Division spoke to the Medical Control Committee to explain the design and functions of the COBRA teams. He explained that the COBRA response teams:

- Are rapid response teams made up of first responders and medical personnel capable of responding either in jurisdiction or out of jurisdiction to a WMD incident with a large number of casualties
- can do agent detection, provide security to the team and conduct medical operations in a potentially contaminated environment or with potentially contaminated patients or patients that have been exposed to WMD or toxic industrial chemicals
- exist in the 14 largest jurisdictions in the state, based on county populations
- Consist of HAZMAT personnel, law enforcement personnel and medical personnel such as paramedics, physicians and possibly, nurses.

Mr. Whitaker said that he is at this meeting, with Tim Gault of Greenville County EMS, to seek approval of protocols for treatment of WMD agents, toxic industrial chemicals. He also presented a draft medical control document for the COBRA teams. He said that in the event of a disaster, the local resources may be overwhelmed and not able to provide medical control for the teams. Mr. Whitaker is seeking permission for the COBRA teams to act independently of local medical control authority. He is seeking for a medical control physician to respond with the teams and for that medical control

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physician to provide direct medical control. If the physician is not there, they want the teams to be able to use standardized treatment protocols. He also said that they are planning for a state level physician to be present in the State Emergency Operations Center and for this physician to provide on-line medical control capabilities.

Dr. DesChamps clarified questions that the planning efforts are striving to develop a standardized set of statewide treatment protocols that could be followed if local medical control is not available during disasters and if another physician is unable to accompany the team into the disaster site. If local medical control is available, that medical control would direct the activities of the team.

Tim Gault said that the proposed protocols were developed from drugs that had already been approved by Medical Control for special purpose use. The protocols are based on the training by the Department of Justice. He said that the drug doses are consistent with the medication on the state formularies.

Dr. Norcross asked if the protocols were developed with drugs/dosages that were already approved, why is the Medical Control Committee being asked to approve the protocols. Any service can develop their own protocols, as long as they use approved drugs/dosages.

Dr. DesChamps pointed out that these COBRA teams are not licensed services. Dr. DesChamps said that the Medical Control Committee is being asked to approve a different kind of service than already exists—a non-transporting, non-EMS service, with a separate medical control physician. Dr. DesChamps said that any physician serving as a COBRA medical control physician will have to attend a medical control physician's workshop and meet the other criteria required of medical control physicians.

Dr. DesChamps said that he wanted the MCC to consider the concept of a state EOC physician.

Dr. Sorrell said that he supported these concepts and that Dr. DesChamps should be the state COBRA medical director. He also asked if the COBRA teams were made of elite paramedics because some of the protocols call for administration of drugs for, e.g., hypocalcemia, and most paramedics will not be familiar with that in the field. He said some of the guidelines could be “tuned up” for the average paramedics.

There was discussion about standardized training for the COBRA team paramedics.

Dr. Fuerst said that this is a good example of why the state should move toward requiring associate degrees for paramedics.

There was then discussion about the liability of the medical control physicians. Mr. Gault said that the paramedics are covered with liability from their regular service. Dr. Norcross asked then about whether the sending service's physician would be held liable for the actions of paramedics serving on the COBRA teams. Dr. DesChamps said that is

why the state should activate the teams and the team's liability coverage should come from the state. Dr. Norcross said there should be some legislation to cover this issue.

Mr. Whitaker said that there is two ways the teams can become active: through a statewide mutual aid agreement which outlines who pays for what and where liabilities are set and it is a statewide document; and the other method is through the state emergency operations center activating a team and the teams become state assets and are covered under state's liability.

Dr. DesChamps requested that Dr. Burger and Dr. Shelton review the proposed protocols and make their recommendations to the Medical Control Committee.

Dr. Sorrell said that the COBRA teams should follow the same training guidelines as all other services.

**Dr. DesChamps said there is a motion on the floor to approve the concept of the document outlining the COBRA teams; to make the protocols as listed effective for the interim; and to ask Dr. Burger and Dr. Shelton to review the protocols and report to the Medical Control Committee. The motion was seconded by Dr. Bynoe. The motion passed.**

Dr. DesChamps said that a letter should be sent to Dr. Burger with this request.

**Dr. Sorrell made a motion that the COBRA training should be reviewed and overseen by the EMS Training Committee and reviewed for in-service training credit. Dr. DesChamps seconded the motion. The motion passed.**

#### **BLOOD EXCHANGE – Meducare**

Dr. DesChamps said that this discussion began at the Medical Control Committee meeting at the EMS Symposium—whether or not paramedics could change out blood during a transport.

George Condon of Meducare reported that the majority of states are functioning as South Carolina—that paramedics are not allowed to change out blood. He said that Meducare was seeking approval to change out already cross-matched, typed blood as needed during long transports. They are also asking if something happened in the back of the truck, for example a paramedic tripped on an IV line and it dislodged, could the paramedic then start another line and continue the infusion. Another question they are asking is if the sending facility had typed and crossed an unusual blood type and wanted to send blood with the patient and hang it, if something happened, would it be permissible to administer the blood already hanging.

Dr. Norcross asked if they had checked with the Nursing Board about the legality of someone other than a nurse changing blood. Mr. Condon said that the Nursing Boards

regulations stipulate that only nurses can change blood, but the regulations were written just for nurses, there was no reference about paramedics.

Dr. DesChamps said that all of the representatives from states that he had checked with did not allow the changing of blood. Dr. Sorrell said he would consider administering Retavase as dangerous a procedure as changing out blood. Mr. Condon said his main concern was long distance transports.

Dr. Norcross said he wasn't as concerned about long distance transports as for trauma patients who are multiply injured and need the blood availability to keep them alive while they are being transported to a trauma center.

Dr. Sorrell said that he is less concerned about paramedics changing blood on one patient, then hospitals that are changing blood on multiple patients and having to match and cross-type blood on multiple patients. He said that if there is a need in the state to conduct this procedure, then the paramedics should be allowed to do that.

*Dr. DesChamps suggested having the DHEC Legal Office research if there is any legal reason this should not be allowed.*

Dr. Sorrell said that he believes that the risk in not changing blood is greater than the risk in allowing it.

Dr. DesChamps said that if blood changes are allowed, paramedics MUST note this on the ambulance run report and attach the blood sticker immediately and must leave the report with the hospital and if the run report is not left, it becomes a licensure issue—it is that important.

**Dr. Norcross made a motion that the Committee approves in principal the concept of infusion of blood products en route by paramedics with blood that has been previously cross matched and typed and pending DHEC Legal Office opinion. This action is not approved for use until further information has been received. DHEC will develop appropriate documentation for this action if this is approved. Dr. Sorrell seconded the motion. The motion passed.**

Mr. Smith asked if this included platelets, plasma, etc. Dr. DesChamps clarified that this includes all blood products.

**TRANSFER OF EMS PATIENTS DIRECTLY TO AN ED TRIAGE AREA – Dr. Gerard**

Postponed due to Dr. Gerard's absence.

**DISCUSSION/DETERMINATION REGARDING MEDICINE STORAGE  
POLICIES – Dr. Sorrell**

Dr. Sorrell said that he has nothing specific to report. He said that the Committee or DHEC needs to address proper storage of medications, especially considering the heat in South Carolina.

He said that he hoped that recommendations could be developed to adopt into policy. For example, that all future purchases of ambulances have proper storage equipment. He said that he thought it cost about \$500 to retrofit current ambulances with proper storage equipment.

Dr. DesChamps said that EMS must be able to document that the meds are being stored in compliance with the drug guidelines.

Dr. DesChamps said this Committee should recommend that the Equipment and Standards Committee review this issue.

**Dr. Norcross made a motion that the Medical Control Committee forward a request to the Equipment and Standards Committee to review this issue and develop a plan to develop a policy and report back to the Medical Control Committee within the year, by the meeting at the EMS Symposium. Dr. Sorrell seconded the motion. The motion passed.**

**DISCUSSION OF USE OF NTG PASTE IN CPAP PILOT PROJECT: Lanny Bernard, Lancaster County EMS**

Dr. DesChamps said that we have approval of sublingual nitroglycerin spray. Lancaster County EMS is using CPAP and on a couple of occasions have had trouble using sublingual nitroglycerin with CPAP because of having to remove the CPAP machine. He said that the service wants to know if they can use nitro paste for patients with chest pain. He said that paste is not currently approved by that route of administration.

*The Committee decided by consensus that paste is not a good route for CPAP patients and that services should continue to use sublingual spray.*

**INCREASE OF NTG DRIPS DURING INTERFACILITY TRANSPORTS – Dr. Cindy Dieringer**

Dr. Dieringer had asked whether a nitroglycerin drip could be increased on a patient who is being transported. The Committee clarified that it had approved adjustments of interfacility drugs with a direct medical order.

**BLOOD PRESSURE CONTROL PRIOR TO HOSPITAL ARRIVAL: Dr. Creese/Dr. DesChamps**

Dr. DesChamps explained that Dr. Creese had called because he has seen a lot of paramedics controlling hypertensive situations in the field with nitroglycerin. Dr. DesChamps said that he believes that there is almost no hypertensive situation that needs

controlling in the field. He said that in the formulary one of the indications for nitroglycerin is hypertension.

Dr. DesChamps said that paramedics are using nitroglycerin just to control blood pressure and are giving a lot of the drug, like 3 shots, wait five minutes and giving another 3 shots. Dr. Sorrell asked if this were being done in conjunction with chest pain and Dr. DesChamps said “no.” Dr. Sorrell felt that hypertensive indication had been added in the drug formulary to be used only with some other clinical issue.

**The consensus of the Committee is that the hypertension indication should be taken out of the nitroglycerin drug page.**

There was then some discussion about converting the drug formulary for use in Palm Pilots and so that it could be downloaded from the web site. Dr. Fuerst suggested that residents are always looking for a senior project. He said that last year two residents did projects with PDAs. *Dr. Fuerst asked to be reminded in an email to follow up on this.*

Dr. DesChamps suggested that it would be great to have the protocols put in this format.

#### **QUESTIONS FROM METROPOLITAN MEDICAL RESPONSE SYSTEM**

There was discussion about the purpose/structure of the MMRS. *Dr. Norcross asked that any mass casualty disaster planning that involves the Level I trauma centers, or any designated trauma centers, should have input from the trauma centers in the development of the plans and the trauma director of each trauma center should be invited to the planning meeting.*

Mr. Smith had received a memo from Howard Lederfind, MMRS Coordinator with questions following up from a meeting held on May 15, 2003.

1. Can an Emergency Medical Technician (EMT) administer Mark-1 Auto Injector (Atropine) and CANNA (Diazepam) Auto Injector to victims at a mass casualty incident?

**A motion was made that Mark-1 kits are approved for use by any level EMT with documented training and with approval of the medical control physician during a “declared mass casualty” situation. The motion was seconded. The motion was approved.**

Regarding CANNA auto injectors: there were questions about who is responsible for this controlled substance and the abuse potential for this drug. The current EMS policy regarding controlled substances would say “no”. There were also questions about who would monitor the distribution, as current policies for controlled substances require.

Dr. Norcross said that the issue is not what the EMT can do, the issue is the potential for abuse of the CANNA injectors and who is responsible for the maintenance/monitoring of the injectors.

**The Committee agreed that EMTs cannot be allowed to administer CANNA kits unless change of administration is made to the drug formulary.**

2. Are there limits to quantities of the kits that may be placed on EMS units?

**The Committee agreed that there are no limits on Mark 1 kits, but CANNA injectors must follow standard control regulations.**

3. Can the kits be transported by helicopter?

**Yes**

4. During a mass casualty incident, there is a possibility of treating 100's of patients very quickly, what about the required paperwork for administering the kits, will the place provided on the Triage Tag be sufficient documentation?

Dr. Sorrell suggested that the drug control staff be consulted on this. **The Committee agreed that any time controlled substances are used full forms must be completed unless Wilbur Harling puts some other guidelines in writing. The Committee asked Mr. Smith to invite Mr. Harling of DHEC Drug Control to the next Medical Control Committee meeting.**

#### **DIVERSION QUESTION: Dr. Bill Cauthen, Carolinas Hospital System**

Mr. Smith explained that a letter was sent from Dr. Cauthen to a DHEC Board Member and the letter was forwarded to him. The letter asks about the "legitimacy for hospitals to continue performing elective surgeries while on EMS diversion."

Mr. Smith said that this is not an EMS issue, but Deputy Commissioner Leon Frishman asked the Medical Control Committee to review the issue so that a response can be forwarded to Dr. Cauthen. Dr. Norcross said that it is not EMS that declares a diversion; it is the hospital that declares the diversion.

**The Committee agreed that it is not EMS' position to decide how the hospitals decide when to divert, but it is EMS' position that it is the hospitals' responsibility to find a hospital for EMS to transport the patients to.**

Mr. Smith said he would respond back to the hospital that it is not EMS' responsibility to decide the appropriateness of diversion, but that the hospitals must make arrangements

for EMS if they do go on diversion. He said he would include a copy of that policy that was originally issued in 1989.

**QUESTION RE: VALIUM AND PROTOCOLS: Dr. Sorrell**

Dr. Sorrell clarified with the Committee that the Committee had agreed that any of the benzodiazepines could be used interchangeably; the Committee said that was correct. Dr. Sorrell said that Charleston County EMS is trying to get away from using Valium, but Valium is the only benzo that is listed in the drug formulary that can be used rectally for children. Dr. DesChamps said that the Committee could not find any documentation that Ativan is effective when used rectally. Dr. Fuerst said that another possibility is to use Ativan by IM.

Dr. Sorrell referred to the RSI protocols. He said that there are a couple of things that should be changed that are minimal. He said that Versed is shown as .02 mg/kg. Dr. DesChamps said he thought the Committee had changed that; that the Committee took the upper limit off that dosage. Dr. Sorrell said he thought that .02 mg/kg was low. He also said that it would be easier to say 1.5 to 4.0, etc, so that it does not have to be calculated and is quick and easy, especially since pediatrics wouldn't fall under these protocols. *Dr. DesChamps said that he would check on this question and possibly change to a general dosing such as 1 to 5.*

With no further discussion, the meeting was adjourned.

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**AGENDA ITEMS NOT COVERED/RESOLVED:**

- Solumedrol Pilot Project
- Transfer of EMS patients directly to an ED triage area

**COMMITTEE ACTIONS/REPORTS NEEDED:**

- Dr. DesChamps to review RSI protocols for dosage change of Versed

**STAFF ACTIONS/REPORTS NEEDED:**

- Letter sent to Dr. Burger requesting that she and Dr. Shelton review the COBRA team proposed protocols and return comments to the Medical Control Committee
- Request for DHEC Legal Office to research legality of paramedics administering blood during transports
- Refer issue of medication storage to Equipment and Standards Committee
- Request to Dr. Fuerst that he ask residents for assistance in developing drug formulary for use in Palm Pilots
- Invite Wilbur Harling to next Medical Control Committee meeting to discuss use/protocols of CANNA injectors
- Letter in response to Carolinas Hospital System re: hospital diversion issues

# MEDICAL CONTROL COMMITTEE

## Minutes

November 20, 2003

<b><u>Members Present:</u></b>	<b><u>Others Present:</u></b>
Ed DesChamps, MD, Chairman	Garrett Clanton, MD, Sumter Co. EMS
Richard Rogers, MD	Alonzo Smith, Director, EMS
John Sorrell, MD	L.E. Squires, Jr., Sumter Co. Fire/Rescue
Carol Burger, MD	Phyllis Beasley, DHEC EMS
Bill Gerard, MD	
Doug Norcross, MD	

### MINUTES FROM JULY '03

Dr. Sorrell noted two errors in the minutes of July 2003—two misspellings on Page 6. **Noting the corrections to be made to the minutes, Dr. Sorrell made a motion to approve the minutes from July 2003. Dr. Burger seconded the motion. The motion passed.**

### SOLUMEDROL PILOT PROJECT

Discussion on the Solumedrol Pilot Project proposal, postponed from March of 2003, was postponed again because of lack of representation from Fort Mill Rescue Squad.

### APPROVAL OF CPAP AS A SKILL

Dr. DesChamps requested that the Committee consider approving CPAP as a state skill. It has previously been used as a pilot project. The Committee agreed that “the science is out there that says it works well.” Mr. Smith asked if it would be optional or a core skill and whether it would be approved for all levels EMTs. Dr. Sorrell said that it should be an optional skill and approved for all levels because it is a simple skill.

**A motion was made to approve CPAP and Bi-PAP as local option skills for all levels EMTs. Dr. Rogers seconded the motion. The motion passed.**

### APPROVAL OF CRITICAL CARE PARAMEDIC STATEWIDE

Critical Care Paramedic has been a pilot project for several years. There are currently two or three services with Critical Care Paramedic programs.

Dr. Burger said that Greenville County EMS quit the program; they ran out of money for it, but she said she thinks it is a good skill.

There was discussion about whether the critical care paramedic skills need to be approved by the Board.

*The Committee decided for the next meeting to review the list of Critical Care Paramedic drugs and skills. Prior to the next meeting, staff should find out whether the skills need Board approval. Staff should also clarify the certification requirement for Critical Care Paramedic; i.e. is it a two-year certification, or how long? Staff should also come with a recommendation on which critical care paramedic course should be approved.*

### **PILOT PROJECT – COMBITUBE FOR BASICS**

Dr. Garrett Clanton presented a pilot project to for EMT-B's to be able to use Combitubes for intubation. He said that Sumter County EMS basics have been mistakenly using Combitubes already; he thought it already was approved at that level because it is in the EMT-B curriculum book.

The Committee decided that the lack of approval of Combitubes for Basics was an oversight and that there was no need to implement that as a pilot project.

**Dr. Norcross made a motion to approve Combitube use for EMT-B's. Dr. Rogers seconded the motion. There was then discussion about adding the use of PTL for Basics. Dr. Norcross amended his motion to include the use of PTL's. Dr. Rogers seconded the amended motion. The motion was approved.**

Dr. Clanton then asked about the use of amiodarone for pediatrics. Dr. DesChamps said that the Medical Control Committee had approved that and was waiting on approval by the EMS-Children Committee, but he found out that the EMS-C Committee doesn't really exist anymore.

**The Medical Control Committee agreed by consensus to continue with the approval of amiodarone for pediatrics and that the dose will be established by PALS guidelines.**

### **ADULT INTRAOSSEOUS PILOT PROJECT – BERKELEY COUNTY EMS**

Berkeley County EMS had submitted a pilot project to implement an intraosseous cannulation program using the Bone Induction Gun. There was not a representative of Berkeley County at the Medical Control Committee meeting. Discussion of this proposal was postponed until a representative of the service was available.

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**REVISION OF RSI PROTOCOL – DR. SORRELL**

This discussion is in response to a letter from Colleton County EMS which poses the following questions:

1. As the protocols are written that you must have online medical control for repeat doses of RSI drugs, communication with medical control for patients being flown to a Level I trauma center is not generally possible. How can this be resolved?
2. If Colleton County uses their base hospital for online medical control, who is responsible for the patient after online medical control? Would receiving orders from the Colleton County ER make the ER responsible for the patient and violate some EMTALA code if the patient is flown to another hospital from the scene after treatment ordered by the local ER?
3. Can Colleton County EMS have clarification on the pediatric age cutoff for Norcuron?

Dr. Sorrell asked the Committee to revise the RSI guidelines to match the DHEC drug list. Dr. Sorrell said that the doses are inadequate and that the Committee needs to let the paramedics know that it is okay to approximate the doses. He also said that the Committee needs to clarify the initial training requirements for RSI; the paramedics already get some of the skills in the ACLS and other types of training.

Dr. Sorrell said that there should only be five hours of additional training if they have had basic airway and trauma assessment.

*Dr. Sorrell said he and Dr. Gerard would make the appropriate changes in the document and forward it to Mr. Smith for Committee review at the next meeting.*

Dr. Burger requested that a repeat of Norcuron be added.

There was then discussion about the 18 age cutoff for RSI. Mr. Smith commented that age 12 is the cut off for LMA use. This was not resolved.

The Committee said that the revision of RSI protocols should address Colleton County's concerns. They also said that online direction from the local ER, then transport to a trauma center would not be an EMTALA violation.

*Staff will send a copy of the current drug formulary to Medical Control Committee members to review for consistency.*

**RE-INSERTION OF TRACH TUBES – DR. SORRELL**

Dr. Sorrell addressed to the Committee whether EMT-P's could re-insert trach tubes. The Committee agreed that it is allowable for mature trach tubes to be re-inserted.

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### **ADMINISTRATION OF ALBUTEROL SULFATE IN ET TUBES**

A request came from Doug Maness with Richland County EMS about altering the routes of administration of albuterol sulfate. He asked if EMT-P's can administer the drug straight down the ET tube in instances of asthma patients in cardiac arrest.

Dr. DesChamps asked why a nebulizer could not be used. Dr. Burger said you have to have special equipment to use a nebulizer with an ET tube.

**The Committee agreed by consensus to allow the administration of albuterol straight into an ET tube in instances of asthma patients in cardiac arrest.**

### **TRANSPORT OF PATIENTS WITH ACUTE MI'S**

Dr. Thomas Martel of Horry County Fire and Rescue called in a request for guidelines on developing protocols for transport of patients with acute MI's to bypass local hospitals to hospitals that can perform angioplasty.

The Committee determined that development of this type protocol is beyond the scope of the Medical Control Committee and is an issue for hospital administrators.

### **REQUEST FOR DIVERSION INFORMATION: WILLIAMSBURG COUNTY EMS**

Williamsburg County EMS wrote for clarification on the following issues:

“Williamsburg County’s rural area is approximately 936 square miles with neighboring facilities being equal to the county’s hospital as far as level of trauma. Is it dumping if we transport from scene to another county’s ER because of location without local MD?

- 1) Do you need hospital/physician acceptance if the first facility diverts an EMS unit after they have given the hospital patient information in their encode?
- 2) Who is liable (EMS/hospital) if you pass 2 facilities and your patient’s condition worsens in route?
- 3) Can we get a clear interpretation on cobra initial laws? Interpretations vary from agency to agency. These laws may not affect larger counties such as Richland and Florence, due to a trauma center being local. However, this issue seems to have a major impact on our department.”

The Committee discussed the memo that was issued in 1989, requesting that if hospitals go on diversion, that they locate hospitals that can take patients and provide that information to EMS.

*Dr. DesChamps requested that we re-send that memo to EMS providers.*

**The Committee agreed that if Williamsburg County has a written trauma transport protocol and follows it, they are okay.**

### **BLOOD EXCHANGE**

Mr. Smith said that Mr. Catoe of staff reported that there is no conflict with the Nurse's Practice Act for EMT-P's to change blood enroute. *The Committee agreed to review this issue again at the drug meeting.*

Dr. Norcross asked if the Red Cross tracks blood. Dr. Gerard said that the issue is whether it is safe for EMS to start blood; it is not a utilization review.

*The Committee requested that a Red Cross representative be invited to the next meeting.*

### **REVIEW OF COBRA PROTOCOLS - (from last meeting)**

Dr. Burger said that she has reviewed the COBRA protocols and they appear to be fine. *Dr. DesChamps asked Dr. Burger to get with Dr. Steve Shelton and discuss them and report back to the Committee.*

### **TRANSPORT OF PATIENTS DIRECTLY TO ED TRIAGE AREA – Dr. Gerard (from last meeting)**

Dr. Gerard reported that some patients are getting unloaded in the lobby.

**The Committee determined that patients should be transferred at least to the triage area or higher and EMS should have the nurse's signature on the ambulance run report. The Committee asked staff to send a memo regarding this to the ED nurse managers and EMS.**

### **CANNA KITS**

Wilbur Harling of DHEC Drug Control was not at this meeting. The Committee requested that Mr. Harling be invited to the next meeting for this discussion.

With no further discussion, the meeting was adjourned. The next meeting of the Medical Control Committee will be the third Thursday of March 2004.

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### **AGENDA ITEMS NOT COVERED/RESOLVED:**

- Solumedrol Pilot Project
- Approval of Critical Care Paramedic as state skill
- Adult Intraosseous Pilot Project
- Revision of RSI protocols
- Decision regarding blood exchange on route

- Approval of COBRA protocols
- Approval of CANNA kits for use by EMT's

**COMMITTEE ACTIONS/REPORTS NEEDED:**

- Revision of RSI protocols: Drs. Gerard and Sorrell
- Review/approval of COBRA protocols: Drs. Shelton and Burger

**STAFF ACTIONS/REPORTS NEEDED:**

- Present list of Critical Care Paramedic skills/drugs for Committee to review
  - Find out if those skills need Board approval
  - Find out how long Critical Care Paramedic certification lasts
  - Find out the recommended Critical Care Paramedic course.
- Memo to field regarding use of Combitubes and PTLs for EMT-B's
- Change drug list to reflect pediatric dosage (PALS) for amiodarone
- Send current drug list to Medical Control Committee members
- Memo to field regarding approval to administer albuterol in ET tubes
- Send '89 diversion memo to field
- Invite Red Cross representative to next MCC meeting
- Invite Wilbur Harling to next MCC meeting
- Send memo to ED nurse managers and EMS re: taking patients to triage area